Submit this document to:
Crime Victims Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP TERMINATION REPORT: FORM VI

Please use this form if you are no longer conducting treatment
Bill Procedure Code 0127C For This Report.

Victim's Name		Cvcp Claim Number
Client's Name (if different than the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) Date of last session: ._____

2) Diagnosis at the time client stopped treatment:

Turn page to continue

3) Reason for termination ***(check all that apply):***

- ☐ Current goals achieved
- ☐ Client choice to terminate treatment
- ☐ Therapist choice to terminate treatment
- ☐ Parent/guardian choice to terminate treatment
- ☐ Client relocated
- ☐ Client unavailable
- ☐ Client referred to other services
- ☐ Other

4) At this point in time, do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, please describe symptoms based on diagnostic criteria for a DSM diagnosis.